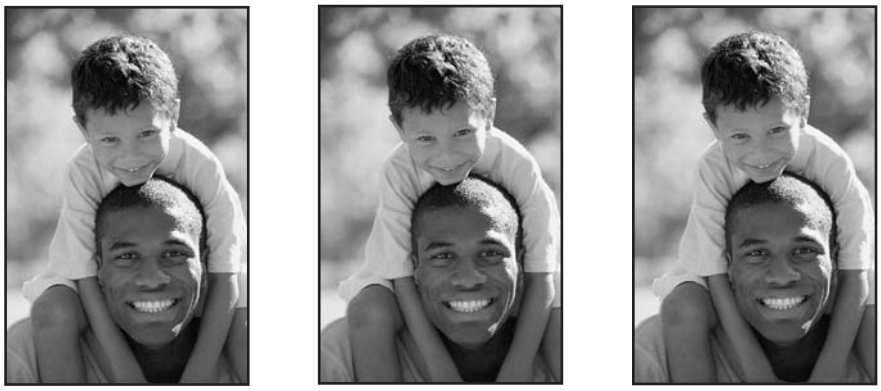
Make Your Smile Count

Survey

Wisconsin Department of Health and Family Services

2001-2002

Preface



In the fall of 2001, the Department of Health and Family Services initiated an oral health screening survey of third grade children in Wisconsin. The survey and analysis were completed early in 2002. This *Make Your Smile Count* survey was funded through a U.S. Centers for Disease Control and Prevention grant awarded to the Department of Public Instruction and the Department of Health and Family Services. This report describes the results of the first, comprehensive oral health survey of children in Wisconsin.

The purpose of the *Make Your Smile Count* survey was to learn about the oral health of children in Wisconsin and in the Department of Health and Family Services' five multi-county regions. Information from the *Make Your Smile Count* survey will assist us in planning future oral health programs.

The survey collected information on caries (cavities) experience, the prevalence of dental sealants, and the need for urgent treatment. The results of the survey will be used to (1) establish a baseline for monitoring children's oral health status; (2) assess the extent of children's oral health needs; and (3) establish and focus prevention programs, policies, and funding.

This report is available on the Department of Health and Family Services Web site (see address below). Comments, suggestions and requests for further information may be addressed to:

Oral Health Program
Office of Public Health Improvement
Division of Public Health
Wisconsin Department of Health and Family Services
P.O. Box 2659
Madison, WI 53701-2659
(608) 266-5152
http://www.dhfs.state.wi.us/health/Oral_Health/

Acknowledgements

Project Direction

Warren LeMay, DDS, MPH
Chief Dental Officer
WI Division of Public Health

Nancy McKenney, RDH, MS
Oral Health Consultant
WI Division of Public Health

Kathy Phipps, DrPH
Epidemiologist
ASTDD Consultant

Project Advisors

Linda Caldart-Olson, RN, MS
Nurse Consultant
WI Department of Public Instruction

Kate Kvale, PhD
Epidemiologist
WI Division of Public Health

David Nordstrom, PhD
Epidemiologist
WI Division of Public Health

Doug White, MS
Assistant Director of Student Services/Prevention and Wellness
WI Department of Public Instruction

Screeners

Kathleen Endres, RDH, CDHC
Midge Pfeffer, RDH, BS, CDHC
Nancy Rublee, RDH, CDHC
Wendy Ruesch, RDH, CDHC
Shirley Arneson Waite, RDH, MPH

Screener Assistants

LaValice M. Hilbert, RN
Joleyn McClemens
Sandy Smith
Carrie Elizabeth Stanek
Crystal D. Sykora

Coordination of Calibration Sites

Freddi Adelson, RN, MS
Health Services Supervisor
Madison Metropolitan School District

Beth Lehman, Principal
Lincoln Elementary School
Madison Metropolitan School District

Bonnie Ohm, RN
Lincoln Elementary School Nurse
Madison Metropolitan School District

The Wisconsin Department of Health and Family Services wishes to thank all the elementary schools and children that participated in the Make Your Smile Count Survey 2002. Major funding for this survey was provided by the Centers for Disease Control and Prevention through the "Oral Disease Prevention in School-Aged Children Using School-based or School-linked Oral Health Programs" grant (Cooperative Agreement U58-CCU516106-04-1).

Contents

Preface ……*i*

Introduction…..……*1*

Sampling ……..……*2*

Methods……..……*3*

Make Your Smile Count 2002 Key Findings

Statewide……..5
By Race and Ethnicity ……..9
By Region ……...15
By Socioeconomic Status ……....17

Estimate of Disease Prevalence…….……*20*

Comparison to Healthy People 2010 Objectives ……..……*21*

Comparison to Other State Surveys ……*22*

Data Tables ……*24*

Appendix A ……*32*

Appendix B ……*33*

Introduction

One of the Federal Healthy People 2010 objectives calls for an oral and craniofacial health data collection system in each state. A public health data collection system is an ongoing systematic collection, analysis, and interpretation of health data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination of these data to those who need to know. A state-based oral health data collection system monitors oral disease status, determines trends, and identifies groups that bear the greatest burden of oral diseases. Policy development and program planning are based on valid and reliable data collected on an ongoing basis.

Dental caries (cavities) is one of the most common childhood diseases. Despite improvements in oral health in the United States, by late adolescence almost 80 percent of children have a history of caries. To establish a baseline for monitoring oral disease trends in Wisconsin, the Department of Health and Family Services, in cooperation with the Department of Public Instruction, conducted a statewide assessment of the oral health status of third grade students attending public schools during the 2001-2002 academic year. This report summarizes the findings of this Make Your Smile Count survey. There is a Data Tables section at the end of this report that presents that data which are illustrated in the figures used throughout the report.

Sampling

A self-weighting sample of elementary schools was obtained for each of the five Department of Health and Family Services regions in the state – southern, southeastern, northeastern, western and northern (Appendix A). A sample is self-weighting when every entity is selected with the same overall probability (chance). A sample is stratified if the population is divided into “strata” or groups, such as the various regions. Within each region, elementary schools were sorted by percent of minority enrollment. Each school in a region had an equal chance of being selected, regardless of minority enrollment. Ordering this list by percent minority enrollment assured that the schools with a wide range of minority enrollment were selected. A simple random sample of elementary schools was then selected for each region (Appendix B). Ninety elementary schools participated in the survey.

All third grade children in the school selected were eligible to participate in the survey. A combination of positive (form received from parent/caregiver indicating child could participate) and passive consent (form received from parent/caregiver only if did not want child to participate) was used to obtain parental consent for a student’s participation. The type of consent used depended on the preference of the school and school district. Response rates varied by region. In the southern, southeastern and western regions, 65 percent of the students took part in the survey compared to 70 percent in the northeastern and 76 percent in the northern region. The statewide response rate for the survey was 67 percent.

Methods

This survey followed the methods outlined in the Association of State and Territorial Dental Directors' 1999 publication *Basic Screening Surveys: An Approach to Monitoring Community Oral Health*. The screenings were completed by five dental hygienists that participated in both a training and calibration session. When a clinical survey is conducted by a team, it is essential that the participating examiners be trained to make consistent clinical judgements (calibration). The objectives of standardization and calibration are:

• To ensure uniform interpretation, understanding and application by all examiners of the codes and criteria for the various diseases and conditions to be observed and recorded.
•To ensure that each examiner can examine consistently.

The screenings were completed using gloves, flashlight, disposable mirror, and explorer. Explorers were only used to verify the presence of dental sealants – they were not used to determine a stick or tug-back in pits and fissures. If necessary, a toothbrush was used to remove excess debris.

The information obtained from the school and during the screening included the following:

- *Child's grade, date of birth, age, gender, race, and ethnicity*

- *Untreated cavities (no, yes)*

- *Caries experience in both the primary and permanent dentition (no, yes)*

- *Sealants on permanent molars (no, yes)*

- *Treatment urgency (urgent need for dental care, early dental care is needed, no obvious problems)*

    - Criteria for urgent care: signs or symptoms that include pain, infection, swelling, or soft tissue ulceration of more than two weeks duration

    - Criteria for early dental care: caries without accompanying signs or symptoms, individuals with spontaneous bleeding of the gums, or suspicious white or red soft tissue areas.

    - Criteria for no obvious problems: any patient without the above problems.

Information on the child's date of birth, race, and ethnicity were obtained from the school based on student enrollment forms. Of the 90 schools that participated in the survey, three refused to provide information on race and ethnicity.

Make Your Smile Count 2001-2002 Survey
Key Findings - Statewide

A total of 3,307 third grade children participated in the survey and were screened (67% response rate). The children ranged in age from 7-10 years with the majority (97%) being either 8 or 9 years of age (mean=8.38, standard deviation=0.54). Half of the children (50.0%) were female and 75 percent were white non-Hispanic. Refer to Table 1 for demographic information.

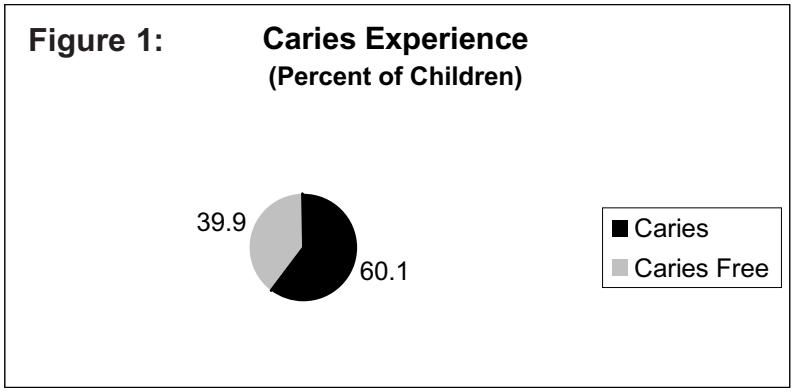
Compared to state enrollment data, “Make Your Smile Count” may have over sampled lower-income schools (Data Table 1, page 27). While 34 percent of all elementary school children in Wisconsin are eligible for the free and/or reduced-price meal program, 39 percent of the children attending participating schools were eligible. The percent of children in need of dental care is assumed to be an underestimation because radiographs (x-rays) were not taken.

Key Finding #1: 39.9 percent of the children were caries (cavity) free.

(See Data Table 2, page 26)

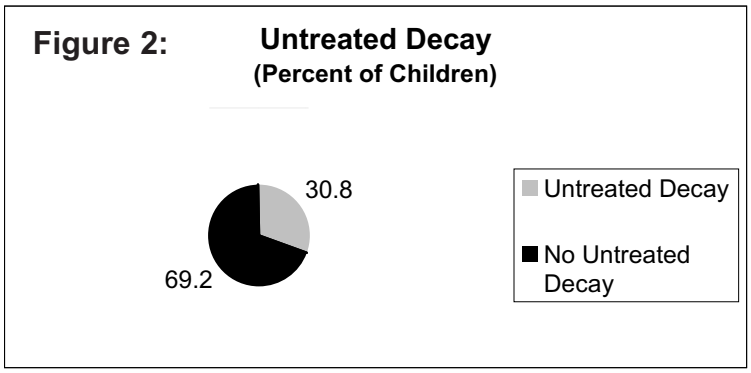
Key Finding #2: 60.1 percent of the children had a history of dental caries – at least one primary or permanent tooth with a filling and/or an untreated cavity.

Figure 1: Caries Experience
(Percent of Children)



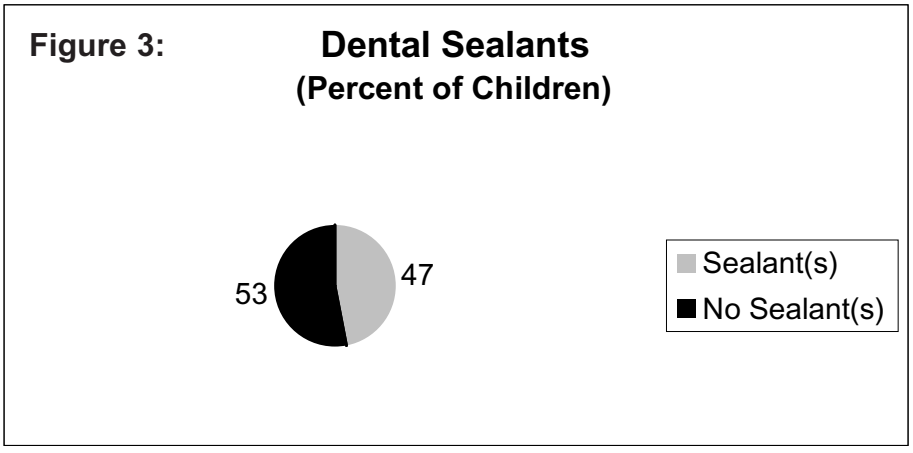
(See Data Table 2, page 26)

Key finding #3: 30.8 percent of the children had untreated decay — at least one primary or permanent tooth with an untreated cavity.



(See Data Table 2, page 26)

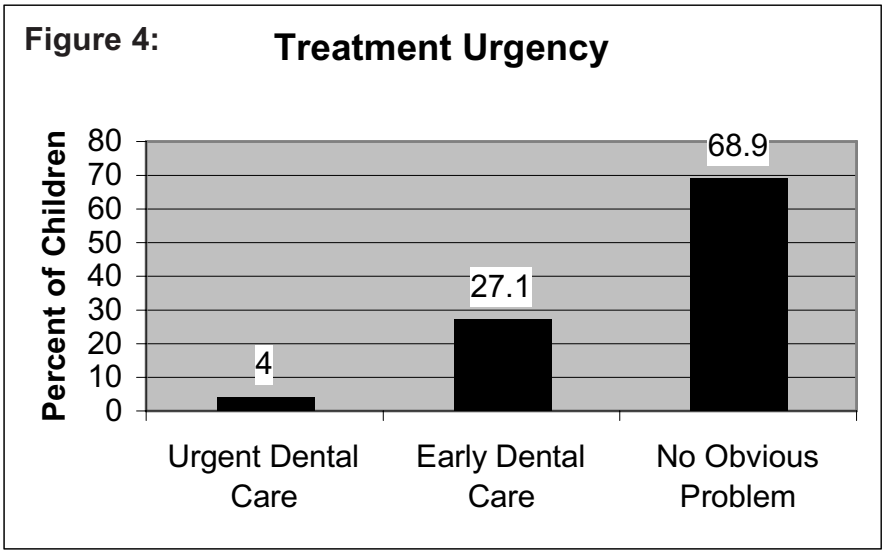
Key Finding #4: 47.0 percent of the children had at least one permanent first molar with a dental sealant – a resin coating that covers the chewing surface of the back teeth making them more resistant to decay.



(See Data Table 2, page 26)

Key Finding #5: 31.1 percent of the children screened needed dental care – 27.1 percent were in need of early dental care while 4.0 percent needed urgent dental care.

Figure 4:



• Criteria for urgent care: signs or symptoms that include pain, infection, swelling, or soft tissue ulceration of more than two weeks duration.
• Criteria for early dental care: caries without accompanying signs or symptoms, individuals with spontaneous bleeding of the gums, or suspicious white or red soft tissue areas.
• Criteria for no obvious problems: any patient without the above problems.

(See Data Table 2, page 26)

Make Your Smile Count 2001-2002 Survey
Key Findings - By Race and Ethnicity

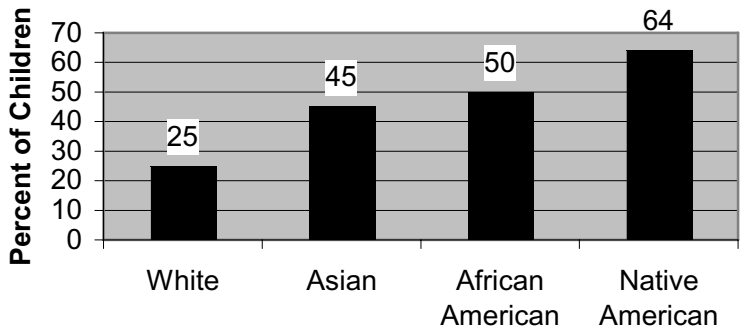
Of the 90 schools participating in the survey, 87 agreed to provide information on race and/or ethnicity. Some schools use a combined race/ethnicity classification rather than two separate classifications; therefore, race or ethnicity data is missing for some children.

Information on race was available for 2,958 children while information on ethnicity was available for 2,520 children.

Key Finding #6: Compared to white children, a significantly higher proportion ($p<0.05$) of minority children had caries experience and untreated decay. Twenty-five percent of the white children screened had untreated decay compared to 50 percent of the African-American, 45 percent of the Asian, and 64 percent of the American Indian children.

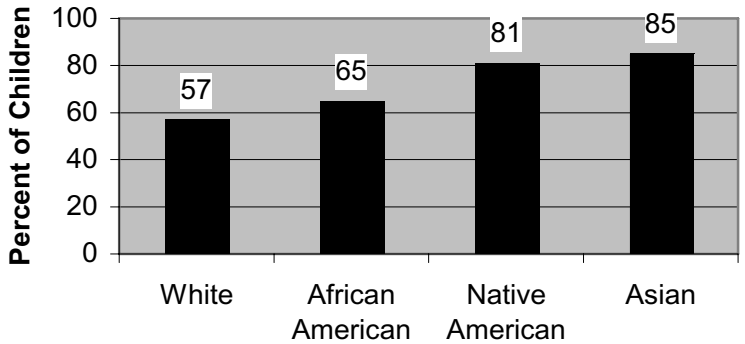
*(Note: $p<0.05$ is a value of statistical significance; p is short for probability, the probability of getting something more extreme than the survey result; equals a confidence interval of 95%)

Figure 5: Untreated Decay by Race



(See Data Table 4, page 28)

Figure 6: Caries History by Race

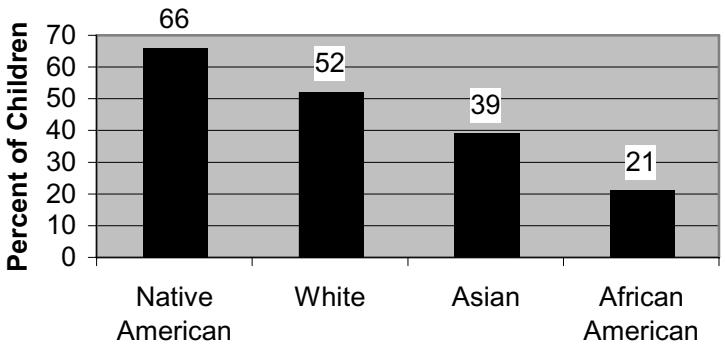


(See Data Table 4, page 28)

Key Finding #7: White and American Indian children were more likely to have dental sealants compared to both African American and Asian children. Of the American Indian children screened, 66 percent had sealants while 52 percent of the white children had sealants ($p>0.05$). Twenty-one percent of the African American children and 39 percent of the Asian children had sealants.

*(Note: $p<0.05$ is a value of statistical significance; p is short for probability, the probability of getting something more extreme than the survey result, equals a confidence interval of 95%)

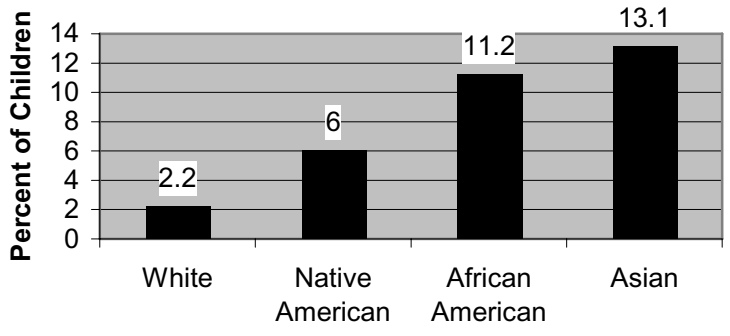
Figure 7: Dental Sealants by Race



(See Data Table 4, page 28)

Key Finding #8: More than 11 percent of the African American and 13 percent of the Asian children were in need of urgent dental care.

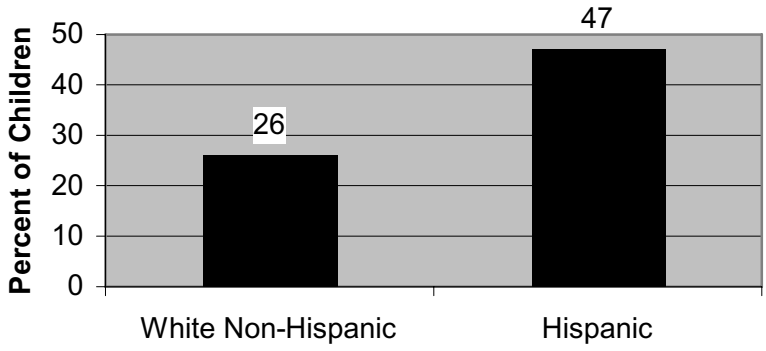
Figure 8: Need of Urgent Dental Care



(See Data Table 4, page 28)

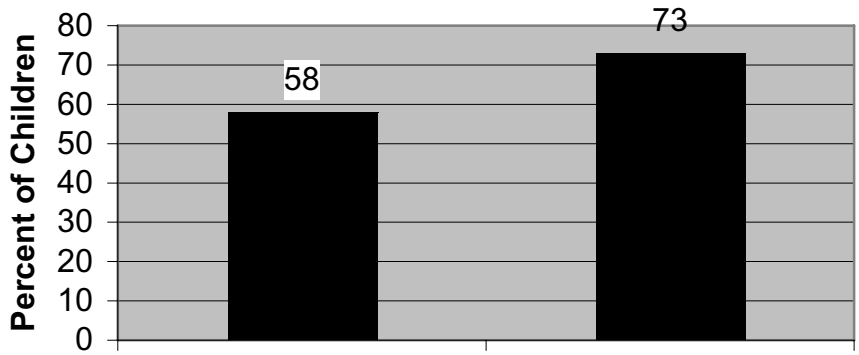
Key Finding #9: Compared to white non-Hispanic children, a significantly higher proportion of Hispanic children had caries experience and untreated decay while a significantly lower proportion had dental sealants.

Figure 9: Untreated Decay by Ethnicity



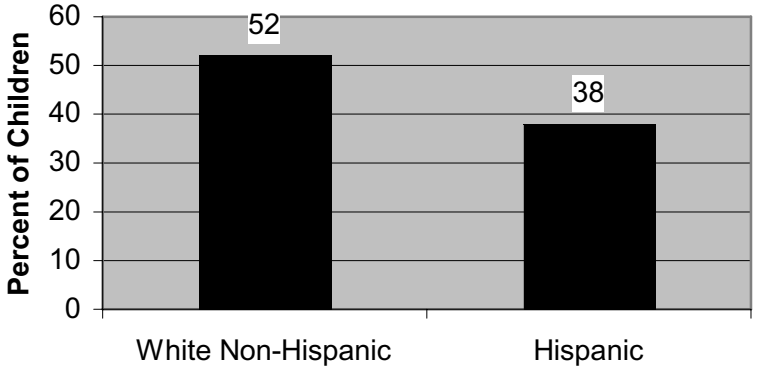
(See Data Table 3, page 27)

Figure 10: Caries History by Ethnicity



(See Data Table 3, page 27)

Figure 11: Dental Sealants by Ethnicity



(See Data Table 3, page 27)

Make Your Smile Count 2001-2002 Survey
Key Findings - By Region

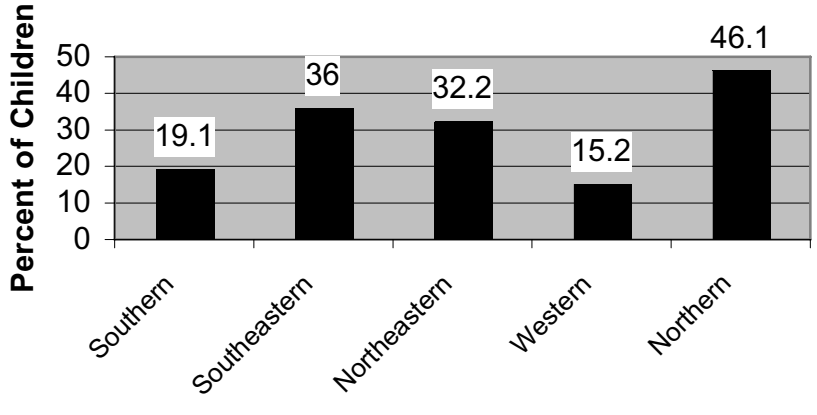
A self-weighting stratified sampling scheme was used to select elementary schools from the five regions within Wisconsin – southern, southeastern, northeastern, western, and northern (See map, Appendix A).

Key Finding #10: 46.1 percent of the children screened in the northern region had untreated decay – significantly higher than any of the other regions ($p<0.05$).

*(Note $p<0.05$ is a value of statistical significance; p is short for probability, the probability of getting something more extreme than the survey result; equals a confidence interval of 95%)

Key Finding #11: 36 percent of children in the southeastern region and 32.2 percent of the children in the northeastern region had untreated decay — a significantly higher proportion compared to children from the southern region (19.1%) or the western region (15.2%).

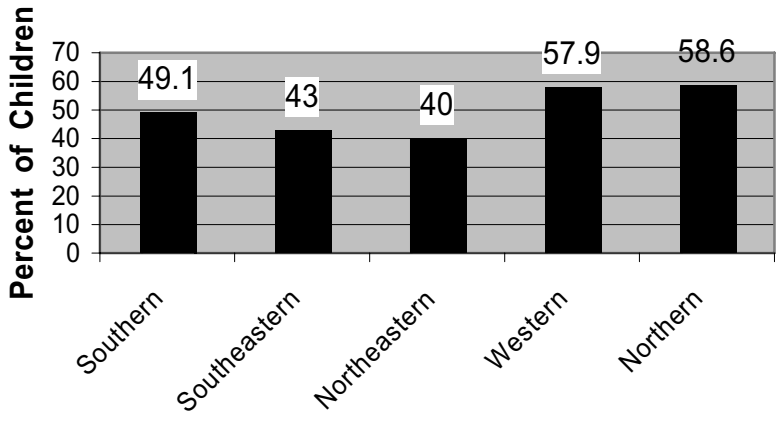
Figure 12: Untreated Decay by Region



(See Data Table 5, on page 29)

Key Finding #12: The prevalence of dental sealants was lowest in the northeastern (40%) and southeastern regions (43%) and highest in the western (57.9%) and northern (58.6%) regions.

Figure 13: Dental Sealants by Region



(See Data Table 5, on page 29)

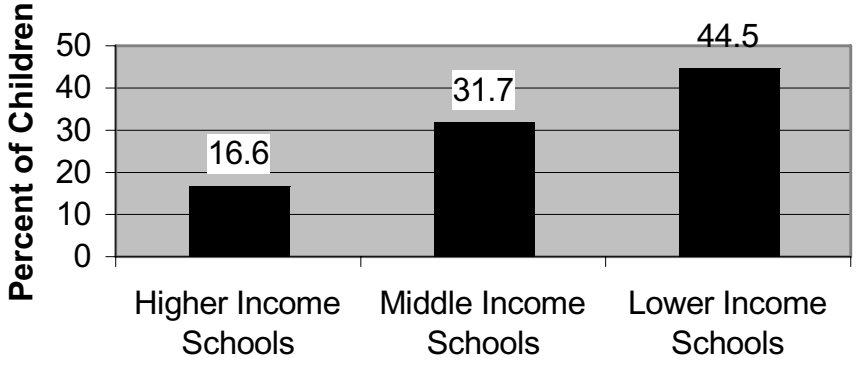
Make Your Smile Count 2001-2002 Survey
Key Findings - By Socioeconomic Status

Our health status is highly associated with socioeconomic status. Information on the proportion of students in each school surveyed who were eligible for the free and/or reduced-price meal program was obtained from the Department of Public Instruction. The data were stratified into the following three income levels based on the proportion of children eligible for the free and/or reduced-price meal program:

- **Higher income schools – less than 20 percent of the children are eligible**
- **Middle income schools – 20-39 percent of the children are eligible**
- **Lower income schools – 40 percent or more of the children are eligible**

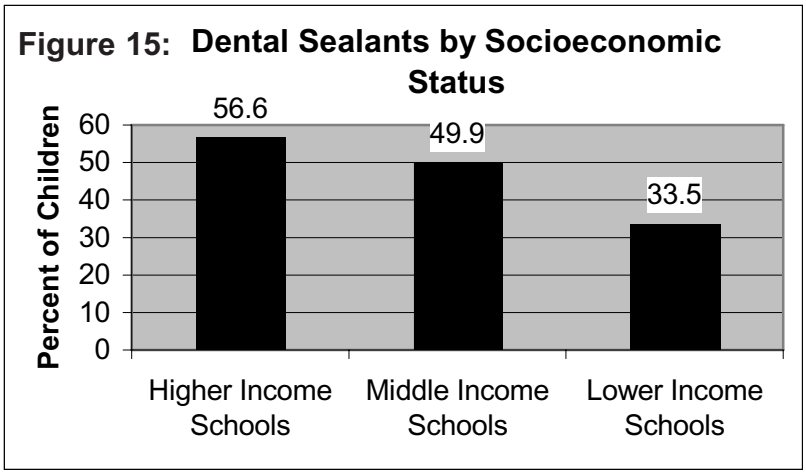
Key Finding #13: Children surveyed who attended lower income schools had significantly more untreated decay (44.5%) compared to children in both middle (31.7%) and higher income schools (16.6%).

Figure 14: Untreated Decay by Socioeconomic Status



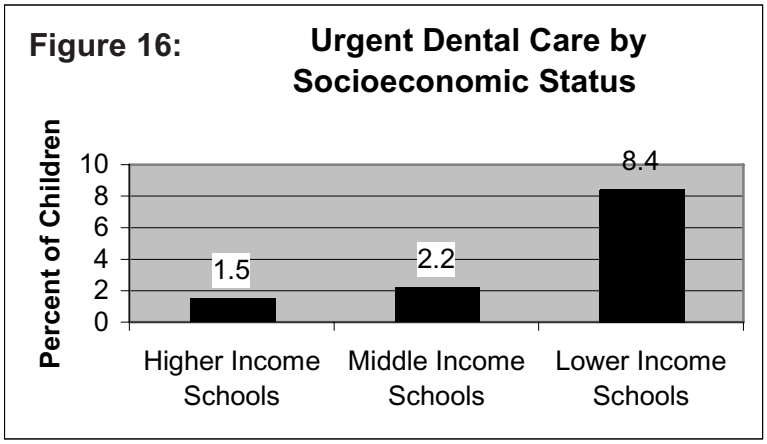
(See Data Table 6 on Page 30)

Key Finding #14: Children attending lower income schools were less likely to have dental sealants (33.5%) compared to children in both middle (49.9%) and higher income schools (56.6%).



(See Data Table 6, on Page 30)

Key Finding #15: Eight percent of the children attending lower income schools were in need of urgent dental care.



(See Data Table 6, on Page 30)

Estimate of Disease Prevalence

The number of children in Wisconsin with untreated decay and restorative treatment needs was estimated using the oral health status estimates obtained from this survey along with data from the Department of Public Instruction. The Department of Public Instruction provided information on the number of elementary school children and participation in the free and/or reduced meal program.

Key Finding #16: Approximately 18,310 third grade children in Wisconsin have untreated decay.

Key Finding #17: Approximately 2,329 third grade children in Wisconsin are in need of urgent dental care because of pain or infection.

Key Finding #18: If the estimated percentages obtained from the survey are applied to all elementary school children in Wisconsin, then approximately 14,376 elementary school children in Wisconsin are in need of urgent dental care because of pain or infection.

(See Data Table 7 on Page 31)

Comparison to Healthy People 2010 Objectives

The federal Healthy People 2010 objectives outline several oral health status objectives for children between the ages of six to eight years. These include:

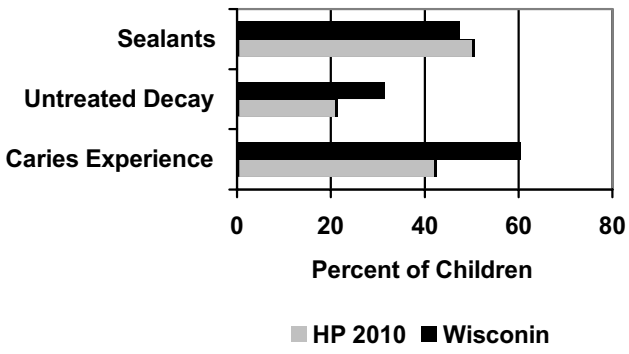
• Decrease the proportion of children who have experienced dental caries in permanent or primary teeth to 42 percent

• Decrease the proportion of children with untreated dental caries in permanent or primary teeth to 21 percent

• Increase the proportion of eight-year-olds receiving protective sealing of the occlusal surfaces of permanent molar teeth to 50 percent

As illustrated in Figure 17, Wisconsin does not yet meet the Healthy People 2010 objectives for caries experience and untreated decay. In terms of dental sealants, Wisconsin is very close to meeting the Healthy People objective.

Figure 17 - Wisconsin Compared to HP 2010



Comparison to Other State Surveys

Other states have recently collected oral health data on third grade children. Like Wisconsin Maine, New Hampshire, New Mexico, Utah and Washington also used the diagnostic criteria outlined in *Basic Screening Surveys: An Approach to Monitoring Community Oral Health*. Since the *Basic Screening Surveys* manual is relatively new (1999), the number of states utilizing this protocol is limited. Similar sampling strategies were utilized and the data is comparable. Of the states completing surveys, only New Mexico children have higher caries experience and untreated decay than Wisconsin.

Figure 18: Caries Experience

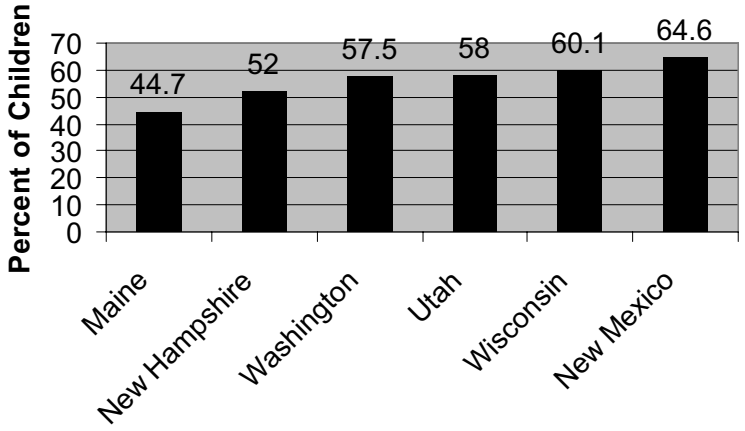


Figure 19: Untreated Decay

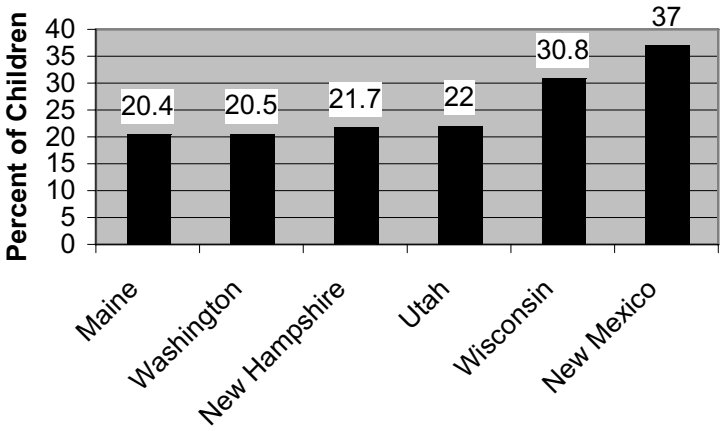
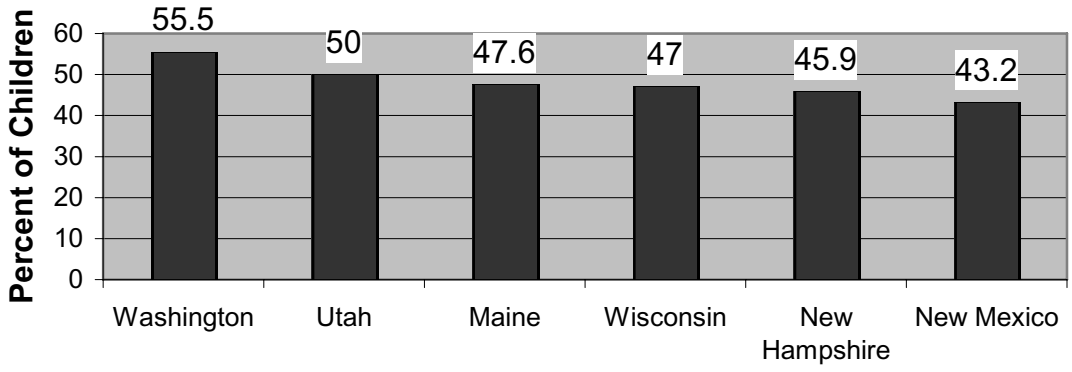


Figure 20: Dental Sealants



Data Tables

Table 1: Demographic Information

	Children Screened	All 3rd Grade Children in State
Number of Children	3,307	62,662
Response Rate	67 percent	not applicable
Age Range Mean (standard deviation)	7-10 years 8.38 (0.54)	Not Available
Gender (n=3,286) % female	 50.0 50.0	 49.0 51.0
Race (n=3,307) % White % African-American % Asian % Pacific Islander % American Indian/Alaska Native % Unknown	 71.7 11.9 3.9 0.0 2.0 10.5	Not Available
Ethnicity (n=3,307) % Not Hispanic % Hispanic % Unknown	 70.3 6.0 23.8	Not Available
Race & Ethnicity (3,098) % White non-Hispanic % African-American % Asian % American Indian/Alaska Native % Hispanic	 74.7 12.7 4.2 2.2 6.4	 78.2 11.6 3.4 1.5 5.3
	Participating Elementary Schools	All Elementary Schools
Socioeconomic Status % of Children Eligible for the Free or Reduced Price Meal Program	38.7	33.5

Table 1 B: Percent of Children by Race and Ethnicity For Only those Children with Known Race or Ethnicity

	Percent of children
Race (n=2,958)	
% White	80.1
% African-American	13.3
% Asian	4.4
% Pacific Islander	0.0
% American Indian/Alaska Native	2.2
Ethnicity (n=2,520)	
% Not Hispanic	92.2
% Hispanic	7.8

Table 2: Oral Health Status Information

Variable	Percent of Children	95% CI
Untreated Decay	30.8	29.3-32.5
	60.1	58.4-61.8
	47.0	45.3-48.7
Treatment Urgency		
No obvious problem	68.9	67.3-70.5
Early dental care	27.1	25.6-28.7
Urgent dental care	4.0	3.4-4.7

*CI = Confidence Interval: the likely range of the true value

Table 3: Oral Health Status by Ethnicity

Variable	White, non-Hispanic		Hispanic	
Number of Children	1,902		197	
	%	95% CI	%	95% CI
Untreated Decay	26.0	24.1-28.1	47.2	40.1-54.4
Caries History	57.8	55.6-60.1	72.6	65.8-78.7
Sealants	51.7	49.4-53.9	37.6	30.8-44.7
Treatment Urgency				
No obvious problem	73.8	71.8-75.8	52.8	45.6-59.9
Early dental care	23.8	21.9-25.8	38.6	31.7-45.8
Urgent dental care	2.4	1.8-3.2	8.6	5.1-13.5

Table 4: Oral Health Status by Race

Variable	White		African-American		Asian		American Indian		Unknown	
Number of Children	2,369		392		130		67		348	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Untreated Decay	25.2	23.4-27.0	50.3	30.0-39.7	45.4	36.6-54.3	64.2	51.5-75.5	35.6	30.6-40.9
Caries History	57.2	55.2-59.2	65.3	60.3-70.0	84.6	77.2-90.3	80.6	69.1-89.2	60.9	55.6-66.0
Sealants	51.5	49.4-53.5	21.4	17.5-25.9	38.5	30.1-47.4	65.7	53.1-76.8	45.4	40.1-50.8
Treatment Urgency										
No obvious problem	74.6	72.8-76.4	49.2	44.2-54.3	53.1	44.1-61.9	35.8	24.5-48.5	64.7	59.4-69.6
Early dental care	23.2	21.5-24.9	39.5	34.7-44.6	33.8	25.8-42.7	58.2	45.5-70.2	31.0	26.3-36.2
Urgent dental care	2.2	1.7-2.9	11.2	8.4-14.9	13.1	7.8-20.1	6.0	1.7-14.6	4.3	2.5-7.2

Table 5: Oral Health Status by Region

Variable	Southern		Southeastern		Northeastern		Western		Northern	
Number of children	503		1,261		727		454		362	
Response Rate	64.5		65.2		70.3		65.4		75.6	
% White*	81.1		60.5		72.6		82.4		82.0	
% Hispanic*	7.2		10.5		2.5		0.9		1.9	
F/R Lunch % in Sample	33		50		26		33		39	
F/R Lunch % in Region	27		41		26		32		34	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Untreated Decay	19.1	15.8-22.9	36.0	33.4-38.7	32.2	28.8-35.7	15.2	12.1-18.9	46.1	40.9-51.4
Caries History	57.1	52.6-61.4	60.7	57.9-63.4	63.0	59.4-66.5	51.8	47.1-56.4	67.1	62.0-71.8
Sealants	49.1	44.7-53.6	43.0	40.2-45.8	40.0	36.5-43.7	57.9	53.2-62.5	58.6	53.3-63.7
Treatment Urgency										
No obvious problem	80.5	76.7-83.8	63.6	60.9-66.2	67.7	64.1-71.0	84.8	81.1-87.9	53.9	48.6-59.1
Early dental care	19.3	16.8-23.1	27.8	25.4-30.4	31.2	27.9-34.8	15.0	11.9-18.7	42.3	37.1-47.5
Urgent dental care	0.2	0.0-1.3	8.6	7.1-10.3	1.1	0.5-2.2	0.2	0.0-1.4	3.9	2.2-6.6

*Percent of all children in region including those with missing data for race and/or ethnicity

Table 6: Oral Health Status by Free/Reduced Lunch** Status of School

Variable	Percent of Children in School Eligible for the Free and/or Reduce Proce Meal Program					
	0-19%		20-39%		40% or more	
Number of Children	1,069		1,124		1,080	
	%	95% CL	%	95% CL	%	95% CL
Untreated Decay	16.6	14.4-19.0	31.7	29.0-34.5	44.5	41.6-47.6
Caries History	51.5	48.5-54.6	61.4	58.5-64.2	67.3	64.4-70.1
Sealants	56.6	53.6-59.6	49.9	46.9-52.9	33.5	30.7-36.4
Treatment Urgency						
No obvious problem	83.4	81.0-85.6	68.1	65.2-70.8	55.0	52.0-58.0
Early dental care	15.1	13.0-17.4	29.7	27.1-32.5	36.6	33.7-39.5
Urgent dental care	1.5	0.9-2.5	2.2	1.5-3.3	8.4	6.9-10.3

Note: One school in the sample does not participate in the National School Lunch Program. For this reason, the sample size in this table is 3,273.

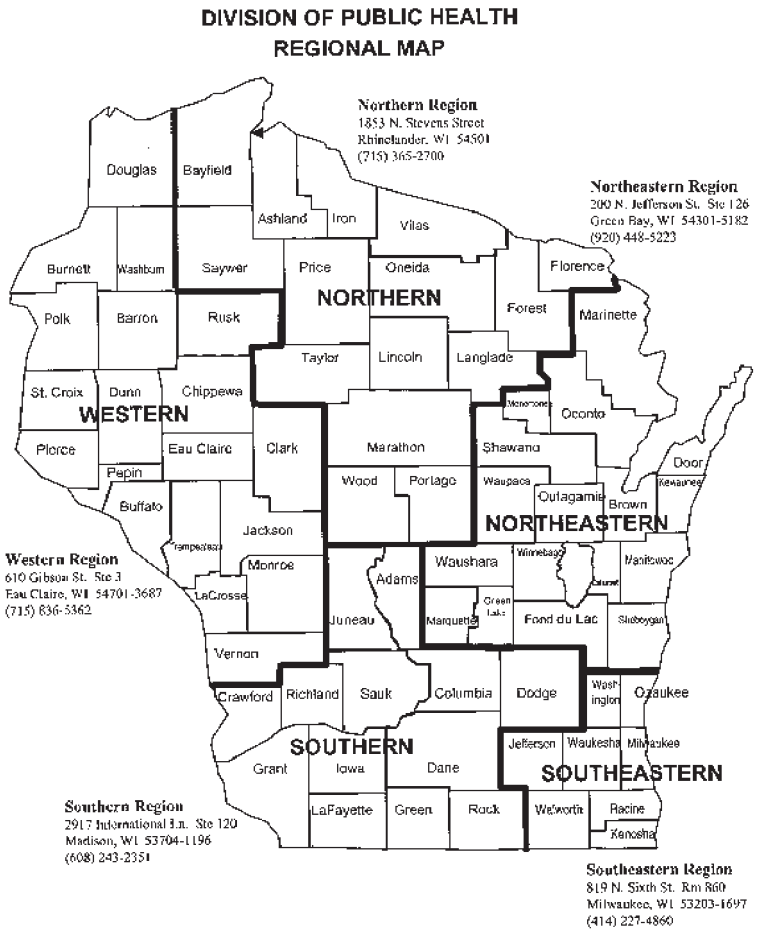
**The free and/or reduced meal program is a federally assisted meal program administered by the U.S. Department of Agriculture at the federal level and the Department of Public Instruction at the state level. School districts that take part in the program get cash subsidied from the Department of Agriculture and they must offer free or reduced price lunches to eligible children. Children from families with incomes at or below 130 percent of the poverty level are eligible for free meals. Those with incomes between 130 percent and 185 percent of the poverty level are eligible for reduced price meals.

Table 7: Oral Health Status by Free and/or Reduced Lunch School Status and Grade

(NOTE: These percents and numbers are estimates only)

Variable	Percent of Children in School Eligible for the Free and/or Reduce Proce Meal Program								
	0-19%			20-39%			40% or more		
	Estimate from survey	Elementary School Children	3rd graders only	Estimate from survey	Elementary School Children	3rd graders only	Estimate from survey	Elementary School Children	3rd graders only
Number of children	1,069	139,114	24,038	1,124	117,570	19,414	1,080	115,504	18,351
	%	# of kids	# of kids	%	# of kids	# of kids	%	# of kids	# of kids
Untreated Decay	16.6	23,093	3,990	31.7	37,270	6,154	44.5	51,399	8,166
Treatment Urgency									
Early dental care	15.1	21,006	3,630	29.7	34,918	5,766	36.6	42,274	6,716
Urgent dental care	1.5	2,087	361	2.2	2,587	427	8.4	9,702	1,541

Appendix A



Counties Within Each Region				
Southern	**Southeastern**	**Northeastern**	**Western**	**Northern**
Adams	Jefferson	Brown	Barron	Ashland
Columbia	Kenosha	Calumet	Buffalo	Bayfield
Crawford	Milwaukee	Door	Burnett	Florence
Dane	Ozaukee	Fond du Lac	Chippewa	Forest
Dodge	Racine	Green Lake	Clark	Iron
Grant	Walworth	Kewaunee	Douglas	Langlade
Green	Washington	Manitowoc	Dunn	Lincoln
Iowa	Waukesha	Marinette	Eau Claire	Marathon
Juneau		Marquette	Jackson	Oneida
Lafayette		Menominee	La Crosse	Portage
Richland		Oconto	Monroe	Price
Rock		Outagamie	Pepin	Sawyer
Sauk		Shawano	Pierce	Taylor
		Sheboygan	Polk	Vilas
		Waupaca	Rusk	Wood
		Waushara	St. Croix	
		Winnebago	Trempealeau	
			Vernon	
			Washburn	

Appendix B

Participating Elementary Schools

Southern

Adams-Friendship, Friendship
Rusch, Portage
Glendale, Madison
Shorewood Hills, Madison
Brooklyn, Brooklyn
Country View, Verona
Lowell, Lowell
Wilkins, Platteville
Ridgeway, Ridgeway
Pecatonica, Blanchardville
Hackett, Beloit
Harrison, Janesville
Newark, Beloit
Grand Avenue, Prairie du Sac
Roche A Cri, Friendship

Southeastern

East, Jefferson
Eagle, Eagle
Columbus, Kenosha
McKinley, Kenosha
Randall, Bassett
Bryant, Milwaukee
Doerfler, Milwaukee
Fernwood, Milwaukee
Grant, Milwaukee
Hi-Mount Blvd, Milwaukee
Lloyd Street, Milwaukee
Palmer, Milwaukee
Honey Creek, Milwaukee
Wheatley, Milwaukee
Bruce Guadalupe, Milwaukee
Wilson, West Allis
Wilson, Wauwatosa
Lyons Center, Lyons
Walworth, Walworth
Farmington, Kewaskum
McLane, West Bend
Merton, Merton
Lake Country, Hartland
Park Lawn, Oconomowoc
Pleasant Hill, Brookfield
Lincoln, Kenosha
Franklin, West Allis
AGAPE Center, Milwaukee
North Lake, North Lake
Glenwood, Greenfield
Humboldt Park, Milwaukee

Northeastern

Doty, Green Bay
Martin, Green Bay
Southern Door, Brussels
Roberts, Fond du Lac
Clay Lamberton, Berlin
Madison, Manitowoc
Merryman, Marinette
Gillett, Gillett
Franklin, Appleton
Hortonville, Hortonville
Bowler, Bowler
Cascade, Cascade
Lincoln, New London
Washington, Neenah
Oakwood, Oshkosh
Langlade, Green Bay
Park, Marinette
Sullivan, Green Bay

Western

Halmstad, Chippewa Falls
Greenwood, Greenwood
Tiffany Creek, Boyceville
Longfellow, Eau Claire
Mindoro, Mindoro
Summit, LaCrosse
Lemonweir, Tomah
Westside, River Falls
Galesville, Galesville
Northwood, Minong
Turtle Lake, Turtle Lake
Meadowview, Eau Claire
Rocky Branch, River Falls

Northern

Butternut, Butternut
Mercer School, Mercer
Jefferson, Merrill
Evergreen, Mosinee
Hewitt-Texas, Wausau
Jackson, Stevens Point
Tripoli, Tripoli
Lac du Flambeau, Lac du Flambeau
Humke, Nekoosa
West, Antigo
Newbold, Rhinelander
Jefferson, Marshfield

For additional copies of this report, please contact:

Oral Health Program
Division of Public Health
1 West Wilson Street
PO Box 2659
Madison, WI 53701-2659
http://www.dhfs.state.wi.us/health/oral_health

PPH 0001 (11/02)